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ABSTRACT

This report describes the implementation and first 6 months of data collection of the required performance outcome measures for children receiving mental health services in Florida, as required under Florida's 1994 Government Performance and Accountability Act. This summary is of data received from August 1996 to January 1997 and includes data for both serious emotional disturbance (SED) and at risk children at admission to services, at 6 months, on the annual anniversary, and at discharge. Data were obtained for more than 6,900 children, of whom approximately 61 percent were male, 73 percent were considered seriously emotionally disturbed, and 22 percent were judged to be at risk for SED. Approximately 73 percent lived with their biological or adoptive families and 78 percent were Medicaid eligible. Outcome measures included: (1) days spent in the community, (2) school attendance, (3) number of child arrests, (4) functional level of the child, and (5) family satisfaction with services. Data are to be used for monitoring contract compliance and to inform the state for planning and long-term decisions regarding services, consumers, and the system of care. Evaluation suggests that there has been widespread acceptance of the new measures and procedures, although insurance of continued agency compliance remains a problem as does scheduling and implementation deadlines. (DB)

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The Children's Performance Outcome Measures: Results after Six Months

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Introduction

In Florida, as in other states, there has been an increased emphasis on accountability and performance-based budgeting as guiding tenets of social policy. This has occurred, in part, as state governments have perceived negative public attitudes toward government spending. Based partly on this concern, the Florida legislature passed the 1994 Government Performance and Accountability Act (Ch. 216.0166. F.S., 1995) that requires state agencies to establish a performance-based budgeting process that will hold both the state agency and their contracted service providers accountable for individual consumer outcomes.

Pursuant to this mandate, beginning July 1, 1996, the Mental Health and Substance Abuse program offices of the Florida Department of Children and Families (DCF) were required to include performance measures in all provider contracts. The state agency, in turn, contracted with the Louis de la Parte Florida Mental Health Institute (FMHI) to assist in the data collecting, analysis, and reporting process. This report describes the implementation and first six months of data collection of the performance outcome measures for children receiving mental health services in Florida. Some of the strengths and weaknesses of the approach are described as well as important considerations in development of state based outcome development efforts.

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Service Context

One of the outstanding features of the performance outcomes project was the very tight deadline for the development and implementation of procedures for the collection of outcome information for all children receiving services from the state. Beginning with little background or history of outcomes assessment, the state identified several critical questions that were to be addressed. Among other questions, the most important included:

- What were the populations of interest in performance outcome monitoring?
- What information, such as population characteristics, needed to be identified?
- What questions needed to be answered to assess the performance of service providers for these populations?
- What measures would be the most appropriate to answer these questions?
- What sources of information might already exist which might fulfill data needs?
- What procedures would be put in place to collect data, and how might these procedures be made a routine part of contracting with the state? and
- How would the reliability and validity of the process be assured?

In order to address the questions identified by the state, focus groups were held with consumers, family members, providers, advocacy groups, and staff from the Department of Education, the Department of Juvenile Justice, Children's Medical Services, and Alcohol, Drug Abuse, and Mental Health. These focus groups developed quickly and had little opportunity for careful analysis, but were nevertheless able to identify and define two target populations for children and youth. These two populations include children with serious emotional disturbance (SED) and children at risk of serious emotional disturbance.

In accordance with the federal definition, children with SED were defined as age 0-17 with a diagnosed mental, emotional or behavioral disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV, and that resulted in functional limitations that substantially interfere with or limit the child's role or functioning in a family, school, or in community activities. The

disability must also be expected to continue for a year and not be a temporary response to a stressful situation. Children "at risk" were defined as between 0-17 years of age, with a need for mental health care for serious situational problems. The child must also be considered at high risk of developing serious limitations in functioning due to emotional distress if services are not provided.

Outcome measures identified as being of greatest interest included: 1) days spent in the community, 2) school attendance, 3) number of child arrests, 4) the functional level of the child, and 5) family satisfaction with services. Information about these outcomes was to be obtained from both published and public domain instruments. Demographic data and information pertaining to arrests, time spent in the community, and school attendance, were collected from the newly created Children's Mental Health Scoring Sheet (CMHOSS). The functional level of the child was measured by the Global Assessment Scale for Children (C-GAS: Shaffer, et al., 1983) and supported by information from the Child and Adolescent Functional Assessment Scale (CAFAS: Hodges, 1996). Family satisfaction with services was defined as family centered behaviors as assessed by the Family Centered Behavior Scale (FCBS: Allen, Petr & Brown, 1995).

Method

Beginning in August, 1995, the state initiated the collection of performance outcome data for all children receiving services funded by the Florida Department of Children and Families or by the federal government through Medicaid. Training for all service agencies was conducted through regional meetings and workshops held within the state. Data were to be collected for all children beginning with the child's admission to a service provider and again at six months, twelve months, and if still present, on the annual anniversary of the child's admission. The final set of data was scheduled for collection at the time of the child's discharge. Data collection was integrated as a regular part of the responsibilities of clinical staff of the service provider. Provider staff were assigned the responsibility of completing the CAFAS, the CMHOSS– which included demographic information, services, current residential setting–and the C-GAS. The completed forms were submitted to FMHI for analysis. To ensure that all children receiving services in the state were included in what was to become the statewide database, an initial assessment was conducted for all children receiving services as of August 1, 1995 regardless of the length of treatment with the state.

The service agency also provided the parent or family member a copy of the Family Centered Behavior Scale. The family member was encouraged to complete the survey and return it to the agency for submission or mail it directly to FMHI for analysis.

Results

This summary includes data received during the first six months of data collection, August, 1996 to January, 1997. Data included were collected for both SED and at risk children at admission, at 6 months, on the annual anniversary, and at discharge. During this period, data were obtained for over 6,900 children. Approximately 61% of the children were male, and the age of children receiving services ranged from a few months of age to over 18 years, with approximately 74% between the ages of 5 and 15 years old. A majority of the children (73%) lived with their biological or adoptive families. Other living arrangements included inpatient settings, residential treatment, group homes, foster homes, and emergency shelters. Approximately 78% of the children were Medicaid eligible. Approximately 73% of the children were considered seriously emotionally disturbed, while 22% were considered at risk for SED.

Discussion

The data collected as part of the performance outcomes project will serve at least two major functions. First, the data are to be used for monitoring contract compliance, as the state is interested in determining if provider agencies are fulfilling their contract obligations to the state and to the consumers in their care. To provide monitoring information, a report format was developed that provided average scores for the service provider on each of the performance outcomes. As seen in Table 1, the report format provides average scores on each performance indicator for the agency along with a state mean. The data are provided for each assessment interval and a separate report is provided for each target population.

Additional information on this report includes a count of the number of consumers the agency has served. The intent is to provide direct and timely information to service providers, district staff, and state officials. Agencies may compare the number of consumers served to their negotiated contracts, and may compare the functioning of the consumers they serve as measured by the performance indicators to the average of all agencies. District and state officials can use the same information to ensure that agencies are serving priority populations and consumer groups who are most in need of services.

The second use of data from the project is to inform the state for planning and long term decision making regarding services, consumers, and the system of care. For example, state planners were especially interested in access to performance outcome measures for children with SED and children at risk for SED. Available measures included days spent in the community, days spent in school, and functioning as measured by the C-GAS and the CAFAS. Average days in school and days in the community for children with SED and at risk for SED are provided in Table 2. Visual inspection of the means appear to reveal few if any real differences between children with SED and children at risk for SED in the days spent in school or days spent in the community.

Table 1
Childrens Year-to-Date Outcome Report
"SED" Target Population
(Quarters I - IV, FY 1996-97)

Performance Outcomes

Provider Number: 999999999
Provider Name: NAME

Total Children Served: 304
Contracted to Serve: 300

	Days in Community				School Days			C-GAS Scores			CAFAS Scores		
Purpose	Prov. Avg	State Avg.	Z	Exhibit D	Prov. Avg.	State Avg.	Z	Prov. Avg.	State Avg.	Z	Prov. Avg.	State Avg.	Z
Admission	27	26.29			21.40	21.03		53	55.47			40.79	
6 mo. annual	30	27.80			22.04	21.97		53	59.72		40	33.22	
Discharge	30	27.22			23.00	21.30		60	61.14			29.96	
Post-admission	30	27.03	0.48	20	22.13	21.48	0.38	54	59.22	-5.04	40	33.06	-0.62

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The lack of apparent differences between the target populations with regard to these performance outcomes may be contrasted with the differences found between the two populations on the CAFAS. As seen in Table 3, large differences exist between the two target populations in average CAFAS scores. Based on this preliminary data, differences that exist at admission between the two populations also carry over to discharge. Further analysis of the CAFAS data suggests that the differences in these two populations may extend to differences in the kinds of problems children present at admission. Future research will investigate differences in target populations and implications for the possible revision or addition of new target populations.

In addition to using the data to understand target groups, the data may also be used to investigate regional differences with regard to special populations and service needs and to understand the service system and its components, such as the use of residential placement. Finally, analysis of the data will provide important feedback regarding the value of the measures themselves. Preliminary analysis of regional system differences already has begun.

Implications for the Field

The first six months of the performance outcomes process has produced both successes and dilemmas. Among the successes has been the wide spread acceptance of new measures and procedures forced on numerous service providing agencies on short notice. The success of this implementation phase of the outcomes project is largely the result of an active process of technical assistance offered to local agencies by phone and face to face contact. In spite of the overall acceptance of the new protocol, the dilemma remains regarding how to ensure continued compliance for all agencies, and how to quickly and efficiently communicate new information and changes in policies and procedures to the field.

Related to this dilemma are the problems brought about by a largely top-down process that did not actively involve the service providers. Channels of communication that might otherwise have been established early in the development of the project do not exist. Without procedures in place for clear communication among service providers, district and state staff, and those responsible for data analysis and reporting, there is

Table 2
Average Days in Community and Days in School for Children with SED and At Risk for SED

	SED				At Risk			
	Community		School		Community		School	
	Days	*N*	Days	*N*	Days	*N*	Days	*N*
Admission	26.5	3544	19.1	2574	26.1	979	19.8	581
6 month/Annual	24.1	489	16.5	224	28.1	148	19.8	72
Discharge	24.6	437	18.3	247	25.9	189	19.3	99

Table 3
Average CAFAS Scores for Children with SED and At Risk for SED

	SED			At Risk		
	Average	*SD*	*N*	Average	*SD*	*N*
Admission	57.8	(27.4)	1912	37.5	(26)	367
6 month/Annual	62.3	(27.5)	87	39.5	(34.9)	19
Discharge	50.0	(31.4)	1655	35.9	(31.1)	59

little formal opportunity to benefit from the experiences and insights of the project participants.

A third dilemma relates to the scheduling and implementation of the project. One of the most difficult tasks has been ensuring that final decisions on policy are made before project phases are initiated. For example, legislatively mandated deadlines were often put into place before final policy decisions were made. Our best solution for these problems has been to help identify clear lines of authority, clear lines of communication, and an emphasis on creative problem solving.

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